

COLORADO DEPARTMENT OF HEALTH CARE POLICY

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

December 3, 2010

John Pilotte, Acting Director Performance Based Payment Policy Staff Center for Medicare Centers for Medicare & Medicaid Services Department of Health and Human Services, Attention: CMS-2480-NC Mail Stop C4-26-05 7500 Security Boulevard Baltimore, MD 21244-1850

RE: CMS-1345-NC Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program

Dear Mr. Pilotte:

I am writing to you on behalf of Colorado's single state Medicaid agency, the Department of Health Care Policy and Financing to provide comment related to CMS-1345 NC Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program under Sections 3021 and 3022 of the Affordable Care Act (ACA) of 2010.

Colorado is currently pursuing an accountable care collaborative (ACC) model to be piloted in regions across the state. The initial plan calls for exclusion of persons who are dually eligible for both Medicare and Medicaid but Colorado is acutely aware that policies defined for a Medicare Accountable Care Organization (ACO) could have far-reaching implications for states interested in using any modification of the model to serve Medicaid and dual eligible clients in the future. It is with this in mind that Colorado has the following specific comments on the stated questions:

What policies or standards should CMS consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by the Center for Medicare and Medicaid Innovation (CCMI)?

Colorado strongly recommends CMS ensure that the Medicare Shared Saving Program and the ACO models tested by the Center for Medicare and Medicaid Innovation provide opportunities for solo and

small practice providers to participate without forcing their participation through an integrated health care services delivery model. Many provider practices that serve vulnerable populations, including persons who are dually eligible for both Medicare and Medicaid, are located in geographic regions where low population density serves as a disincentive for the development of integrated health systems. In addition to policies that permit provider practices to interact in a federated model, Colorado recommends CMS develop financing mechanisms that allow direct federal funding of certain infrastructure costs associated with the capacity and expertise to: conduct service utilization pattern analyses, best practices/chronic condition-self management information dissemination, care coordination with community agencies, and electronic health information sharing.

What payment models, financing mechanisms or other systems might CMS consider, either for the Shared Savings Program or as model under CMMI to address the issue of small practices having limited access to capital or other resources to fund efforts from which shared savings could be generated?

Colorado is very concerned that provider practices serving vulnerable populations, including persons who are dually eligible for both Medicare and Medicaid, are likely to be undercapitalized. Some of these concerns can be addressed by policies that permit provider practices to interact in a federated model with direct federal funding of certain infrastructure costs associated with the capacity and expertise to conduct service utilization pattern analyses, best practices/chronic condition-self management information dissemination, care coordination with community agencies, and electronic health information sharing. Additionally Colorado recommends that CMS maximize the demonstration opportunities available under the Center for Medicare and Medicaid Innovation to make prospective payments to ACO models that could be characterized as Special Needs Plan (SNP) versions of the ACO model.

How should CMS balance the opposing points of view in developing patient attribution/ assignment? (Assigned at start versus attributed at end of performance and counting only those who were actively engaged).

Colorado's primary concern and interest is related to serving vulnerable populations, including persons who are dually eligible for both Medicare and Medicaid. In our experience, it can be challenging to engage these clients and to accurately assess their health care needs and risk for services in intensive settings such as inpatient hospitals and emergency departments. Colorado strongly recommends that CMS assign clients at the start so that measurement of an ACO's performance explicitly includes the ACO's success in client engagement, assessment of client risk and clinical intervention. Attributing clients at the end of a performance period may certainly provide information about how well an ACO performs for clients that actively seek treatment but Colorado believes it is more important to intervene with clients that may traditionally fail to seek care or fail to do so in a timely manner.

How should CMS assess beneficiary and caregiver experience of care as part of the assessment of ACO performance?

Colorado's primary concern and interest is related to vulnerable populations, including persons who are dually eligible for both Medicare and Medicaid. In Colorado's experience many dual eligible clients may not be primary English-speakers or may be persons with a disabling condition. Colorado strongly recommends that whichever tools CMS employs to measure beneficiary or caregiver experience must recognize the need for communications and interventions to be culturally appropriate and respectful of client needs and preferences. Satisfaction measures should address not only the beneficiary's satisfaction with the level of support provided but Colorado suggests the measure include

the extent to which beneficiaries know whom to call and perception of that responder's familiarity with the individual's needs. Colorado also recommends that CMS ensure that performance data collection activities will result in sufficient representation of vulnerable beneficiaries, including those persons who are dually eligible for both Medicare and Medicaid, for statistical validity.

What aspects of patient-centeredness are particularly important for CMS to consider and how should those aspects be evaluated?

Colorado recommends that in additional to beneficiary satisfaction measures, CMS adapt existing standards from the Medical Home Domains of *family-centered*, *culturally competent* and *compassion* for use in measuring patient-centeredness. Colorado also suggests that vulnerable populations, especially those with ongoing chronic care needs should prompt the inclusion of performance measures such as the percentage of such clients with individualized care plans.

What quality measures should the HHS Secretary use to determine performance in the Shared Savings Program?

Colorado recognizes the need to focus on high cost facility-based measures such as avoidable hospital readmissions, emergency department visits and skilled nursing facility admissions, but suggests that the HHS Secretary look beyond those measures. In addition to measuring aspects of care transition from facility-based care to the client's return home, Colorado recommends that performance measures include: health status measures such as self-reported depression and physical activity levels; preventive care services utilization; patient satisfaction; patient compliance with discontinuation of certain prescriptions when new, substitute medications are prescribed; and utilization patterns of imaging services.

What additional payment models should CMS consider in addition to the ACA proposed incentive payment as a portion for savings achieved in excess of an established annual minimal level? What are the relative advantages or disadvantages of such an alternative? (As laid out in Section 1899 (d)).

Colorado believes that the benchmarking process provided for in Section 1899(d) is conceptually similar to an actuarially sound capitated rate setting process. While the mechanisms may vary, both processes, establishing a benchmark and establishing a capitated rate, involve contingent future estimates of future period costs. CMS will have a difficult task ensuring that benchmarks are appropriate to the populations and the geographical areas served. Given that, CMS should consider the following suggestions:

ACOs serving a disproportionate share of the Medicare/Medicaid dually eligible population may be at particular risk for adverse selection relative to a benchmark constructed on a broader population. CMS should consider benchmarks purposefully built for the dually eligible population.

CMS ought to validate the assumptions inherent in the benchmark provided for in Section 1899(d) by analyzing costs of a contemporaneously eligible but not enrolled peer population as a pseudo-control group. CMS also ought to examine simple utilization statistics, such as inpatient hospitalizations, readmissions, emergency department use, and nursing facility admissions for the enrollees on a pre/post study basis. While CMS might consider payment to ACOs based on these factors in addition to shared savings relative to the benchmark, CMS might also consider using these additional data to adjust or inform the benchmark calculation.

Colorado's primary concern and interest is related to vulnerable populations, including persons who are dually eligible for both Medicare and Medicaid. Colorado recommends that CMS consider, in addition to the ACA provided incentive payment, additional incentives to ACOs providing services to dually eligible individuals for meeting certain performance benchmarks. Colorado recommends that these additional incentives be for costs or activities that cross or have joint consequences for both the Medicare and Medicaid systems. Colorado believes that financing these additional incentives is within the statutory authority of the Center for Medicare and Medicaid Innovation and the Federal Coordinated Health Care Office. Colorado furthermore recommends that CMS consider mechanisms by which these additional incentives are jointly funded and financed by the cooperative efforts of Medicare and individual state Medicaid programs.

Thank you for the opportunity to provide comment on suggested changes and considerations to enhance the Accountable Care Organization model's utility for vulnerable populations, including those individuals eligible for both Medicare and Medicaid. Should you have any questions, I can be reached at Barbara.prehmus@state.co.us or via telephone at (303) 866-2991.

Sincerely,

Barbara B. Prehmus, M.P.H. Federal Policy & Rules Officer

Cc: Ms. Joan Henneberry, Executive Director

Ms. Lorez Meinhold, Director of Health Reform Implementation & Senior Health Policy Analyst, Colorado Governor Bill Ritter, Jr.

Ms. Cynthia Mann, Center for Medicaid, CHIP, Survey & Certification

Mr. Jonathan Blum, Center for Medicare